

MASCULINE GENDER ROLE CONFLICT AND PSYCHOLOGICAL WELL-
BEING: A COMPARATIVE STUDY OF HETEROSEXUAL AND GAY MEN

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Masculine gender role conflict (MGRC) occurs when externally-imposed male gender role expectations have a negative impact on and consequences for men. The purpose of this study was to examine how men in a homogeneous setting (i.e., a college campus) compare on MGRC and psychological well-being, based on their self-identified sexual orientation. Utilizing canonical correlation analysis, 96 heterosexual men and 102 gay men were compared on four factors of MGRC (conflict between work and family, restrictive emotionality, restrictive affectionate behavior between men, and success, power, and competition) and five factors of psychological well-being (anger, anxiety, depression, self-esteem, and attitudes toward seeking psychological help). Findings for the heterosexual men were highly consistent with previous studies on MGRC and psychological well-being in a college-age population. Findings for the gay men indicated they had more problems with MGRC and psychological well-being than college-age and older gay men surveyed in the one published study on gay men and MGRC. Gay men who were single also reported more problems with restrictive emotionality, anger, anxiety, and depression, and had lower self-esteem, than gay men who were in a relationship. Between group differences were few, with gay men reporting significantly less restrictive affectionate behavior between men than heterosexual men. There were no significant differences between the two groups on any of the psychological well-being variables, indicating that the gay men were no more pathological than the heterosexual

men with respect to their psychological well-being. Overall, the psychological well-being of both populations was seen to suffer as a result of increased MGRC. Implications are discussed for psychological interventions with men who are bound by traditional male gender role stereotypes.

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CHAPTER 1

INTRODUCTION

In the history of American culture, the decade of the 1970s was notable, among other things, for the emergence and prevalence of conflict between men and women over issues related to gender. This so-called “battle of the sexes” led numerous researchers in the United States to initiate a more precise focus in social science research on issues of importance to the understanding of sex and gender.

Many of the conflicts between men and women that came to be scrutinized in the 1970s have persisted through the subsequent two decades and into the new millenium. In addition to these long-standing concerns, new problems between men and women, as well as problems both among men and among women, have come to light since the 1970s, and have provided fertile ground for social science researchers interested in gender issues. Notably, American ideas about masculinity and about traditional male gender roles in the United States have come to be examined more closely (Sharpe & Heppner, 1991; Sharpe, Heppner, & Dixon, 1995).

Trends in Masculinity Research

Specific examples of the proliferation of interest in gender roles and masculinity have emerged over time in the research literature. O’Neil (1981) described the three components that he felt were central to the understanding of how the elements comprising American culture’s definition of masculinity can affect both physical and psychological health and well-being among men: *gender roles*, *gender role socialization*,

and *gender role conflict*. *Gender roles* are the behaviors and expectations that a given culture defines as being masculine or feminine, and that are valued as being appropriate for either men or women. *Gender role socialization* is a developmental process, and involves the acquisition and internalization of attitudes, behaviors, and values that a given culture associates with both masculinity and femininity. *Gender role conflict* is a state that occurs when gender role expectations and behaviors imposed by the culture have a negative impact on and consequences for on the individual, or for others with whom the individual interacts. Such negative impacts and consequences may take the form of either the individual feeling inhibited in his ability to achieve his full human potential, or of his inhibiting the ability of others to achieve their full potential. The degree of the negative impact and consequences will be seen to vary among different men based on a variety of factors, such as age, socioeconomic class, race, ethnicity, and the nature of their early gender role socialization (O'Neil, 1981; Stillson, O'Neil, & Owen, 1991).

In American culture, stereotypes about traditional male gender roles have typically include expectations of leadership, assertiveness, dominance, strength of personality, forcefulness, aggression, willingness both to take risks and to take a stand, independence, and defense of one's beliefs. Stereotyped gender roles that have been considered characteristically female (and distinctly unmasculine) include expectations of gentleness, tenderness, compassion, warmth, sympathy, sensitivity, affection, understanding, and love of children (Martin, 1987). Inherent in these stereotypes are a considerable number of attitudes and assumptions about exactly what it means to be masculine or feminine. O'Neil (1981), in summarizing a decade's worth of research on men and masculinity published in the 1970s, culled from the literature the following

traditional attitudes and beliefs about masculinity that were deemed inherent in stereotyped male gender roles:

- 1) Men, being biologically superior to women, had greater potential as humans than did women;
- 2) Masculinity was the superior, dominant, and more valued form of gender identity;
- 3) Essential to a man's ability to prove his masculinity were power, dominance, competition, and control;
- 4) Any sort of feeling, emotion, or vulnerability was inherently feminine, and was therefore to be avoided;
- 5) Any sort of interpersonal communication that emphasized human emotion, intuition, feelings, and physical contact was inherently feminine, and was therefore to be avoided;
- 6) Having sex was one of the primary ways men proved their masculinity. Therefore, affection, sensuality, and intimacy, being inherently feminine, were to be avoided.
- 7) Intimacy and vulnerability with other men were to be avoided. Because he could be taken advantage of and lose the upper hand, a man could not be vulnerable with a male competitor. Also, intimacy with another man implied both femininity and possible homosexuality.
- 8) Work and career success were measures of masculinity.
- 9) Since men were superior to and different from women in career abilities, a man's role was that of economic provider and caretaker of his family.

It is the individuals who have been taught or have acquired the most rigid of these stereotypes about masculinity and femininity who are most likely to suffer from (or impose upon others) the aforementioned inhibitions. Such rigidly socialized stereotypes about masculinity and femininity are a primary contributing factor to gender role conflict. This conflict is most likely to occur when an individual experiences discrepancies between his actual self and the ideal concept of self that his culture has imposed on him, based on his gender. The resulting cognitive dissonance and psychological distress can be considerable. Given this, it is little surprise that O'Neil (1981) believed that an understanding of these rigid stereotypes is "central to understanding how sexism violates both men and women. [Rigid gender role stereotypes] violate women because the male value system devalues and restricts women's feminine attitudes, values, and behaviors. [They] violate men by denying them the opportunity to express their femininity, therefore denying them important parts of themselves" (p. 205).

O'Neil et al. (1986) conceptualized gender role conflict in men as stemming from four complex and interrelated dimensions: cognitions, affective experience, behaviors, and unconscious experience. Cognitions related to gender role conflict involve how individuals think about their gender roles in relation to beliefs about masculinity and femininity. Affective experiences of gender role conflict involve the feelings individuals have about gender role expectations, both their own and those held by others. Behaviors related to gender role conflict involve the influences that gender role expectations have on our responses to and interactions with others, as well as internal limitations on acceptable and unacceptable behaviors that are masculine or feminine in nature.

Unconscious components of gender role conflict are simply those repressed intrapsychic processes about gender roles that are not in conscious awareness.

Masculine Gender Role Conflict

Rigid masculine gender role socialization, which involves sexism, devaluation and subordination of feminine characteristics, and a fear and avoidance of all things considered feminine, can result in masculine gender role conflict (MGRC). O'Neil (1981) identified six factors characteristic of MGRC that emerge from these behaviors.

1) Restrictive Emotionality. Difficulty with expressing one's feelings in an appropriate manner, and/or denying the rights of others to express their emotions, are characteristic of restrictive emotionality. The implication here is that men will have difficulty openly expressing their feelings, that they will be unwilling to give up emotional control, and that being vulnerable will be problematic. Difficulties will be evident with self-disclosure, recognition of feelings, and processing emotional experiences, all of which are viewed as feminine and to be avoided.

2) Socialized Control, Power, and Competition. Males, socialized from an early age to believe that power and control are essential for self-esteem and a positive self-image, are also taught that competition is the key to obtaining power and control. Behaviors characteristic of this factor include a striving for authority and influence over others, regulation, restraint, and command of others, and a drive to continuously compare oneself to and establish superiority over male competitors. Power is likely to be viewed as a commodity in short supply and as something to be taken from others. Power, control, and competition will tend to be emphasized over healthy interpersonal relationships.

3) Homophobia. Most men who fear femininity also fear homosexuality. Stereotypical beliefs about homosexual men typically include assumptions of femininity and effeminacy. Therefore, a man who is homosexual, or who even associates with homosexuals, may be perceived as possessing these stereotypical traits. Thus, men who fear their femininity will go to great lengths not only to avoid homosexuals, but to avoid any behavior that may be perceived as feminine and therefore homosexual in nature. This factor, while involving all the behaviors characteristic of restrictive emotionality with other men, also tends to be characterized by avoidance of physical affection with men, as well as labeling as homosexual any male who exhibits feminine traits of any kind.

4) Restrictive Sexual and Affectionate Behavior. In addition to restrictive emotionality, rigidly socialized men may tend to feel that physical affection and sensuality of any kind are feminine and inappropriate. Also, the expression of sexual needs, as well as the willingness to take on a sexually passive role, may be seen as too threatening to the idea of masculinity to be experienced. In sexual relationships, partners may be viewed simply as a necessary component in an objective, impersonal process, rather than as an equal in a subjective, intimate process (i.e., as a sperm receptacle rather than as a lover). The emotional vulnerability that can so profoundly deepen the meaning of a sexual relationship will likely be nonexistent.

5) Obsession with Achievement and Success. In addition to control, power, and competition, many rigidly socialized men will equate achievement, influence, ambition, and wealth with masculinity. To attain necessary levels of achievement and success, many men become obsessed with power, status, and success, a need to control and manipulate others, and develop a pervasive mistrust of others who are viewed as

competitors. Such obsessiveness can result in a focus in mens' lives not on home, family, recreation and relaxation, but on combativeness, competition, and struggle. Effective parenting and successful interpersonal relationships are sacrificed in the name of rigid ideas about achievement and success.

6) Healthcare Problems. The rigid gender role stereotype of men as stoic, tireless, and invincible, particularly in the face of physical health problems, has created a tendency among many men toward ignoring symptoms of both acute illness and chronic health problems. Men with rigid gender roles tend to view illness and infirmity as signs of weakness. Weakness, in turn, is associated with femininity. Men traditionally are worse off than women with respect to good nutrition, physical fitness, and the ability to handle stress effectively. Many rigidly socialized men equate masculinity with such things as tolerance for discomfort and pain, limited need for rejuvenating rest, and the ability to ingest large quantities of alcohol (or other drugs), among other unhealthful behaviors.

In summarizing the considerable body of research on masculinity generated during the decade of the 1970s, O'Neil (1981, 1982) consistently identified one core theme, which he believed was the prevailing element in (and driving force behind) each of the aforementioned six factors of MGRC: mens' basic fear of femininity. The pervasive effects of such fear, and the behaviors they produce, can be remarkable. In a comparative longitudinal study of the psychological well-being of men and women, Umberson et al. (1996) found notable gender differences among the 2,867 subjects in their study. Compared to women, the men in the study reported significantly less social integration with others, less social support from friends, and a decreased likelihood of having a confidant. Overall, men were less involved and less invested in social

relationships. Compared to women, men reported significantly less social support from their children. Men reported significantly more strain in their relationships with their spouses and their parents. Men were also significantly more likely to allow their spouse to regulate their healthcare. Fisher and Good (1997) theorized that men who were more emotionally constricted were also more likely to lack social support, and thus have more difficulty coping with problematic life events.

Measuring MGRC

Problems encountered in much of the preliminary research into men's gender role issues included the lack of consistency in the constructs that were used to define gender role conflict, as well as the lack of a psychometric instrument to measure such constructs. Prior to the mid-1980s, much of the research on men's gender issues utilized the Personal Attributes Questionnaire (PAQ; Spence & Helmreich, 1978). Results from studies utilizing the PAQ found, with relative consistency, that men who scored as more highly "masculine" on the PAQ were found to also have more self-confidence, greater self-esteem, less depression, and to be more internally located. However, Spence (as cited in Good et al., 1996) acknowledged that the PAQ was not a measure of masculine or feminine gender *roles*, but was instead a measure of masculine or feminine *personality traits*, more specifically the traits of expressiveness and instrumentality.

In an attempt to help alleviate some of these problems, O'Neil et al. (1986) developed a scale to measure and validate the six factor model of MGRC. In the course of creating their new instrument, the researchers hypothesized that items they had created would cluster into the six factors O'Neil (1981) had identified as characteristic of MGRC: Restrictive Emotionality; Socialized Control, Power, and Competition;

Homophobia; Restrictive Sexual and Affectionate Behavior; Obsession with Achievement and Success; and Healthcare Problems. Utilizing a sample of 527 undergraduate males, the researchers subjected the obtained results to standard factor analytic procedures to obtain the best factor structure and most robust items for the measure. Results from the data analysis were used to create the Gender Role Conflict Scale (GRCS), and were as follows. The researchers determined the best factor structure for the GRCS involved four (rather than six) factors of MGRC:

Factor 1 - Success, Power, and Competition - behaviors characteristic of a drive for achievement, authority, control of others, and struggle against others for personal gain.

Factor 2 - Restrictive Emotionality – behaviors indicative of problems with self-disclosure, as well as with the emotional disclosures of others.

Factor 3 - Restrictive Affectionate Behavior Between Men – behaviors that indicate discomfort with demonstrating affection and concern for other men.

Factor 4 - Conflicts Between Work and Family Relations – distress experienced when work or school interferes with personal and family life.

Internal consistency reliability scores (Cronbach's α) for the four GRCS factors were as follows: Factor 1, $\alpha = .85$; Factor 2, $\alpha = .82$; Factor 3, $\alpha = .83$; and Factor 4, $\alpha = .75$.

Four-week test-retest reliabilities for the four GRCS factors ranged from .72 to .86.

With regard to the original six factors of MGRC that O'Neil (1981) had identified, two of the factors (Homophobia, and Restrictive Sexual and Affectionate Behavior) were combined into other categories, one factor (Obsession With Achievement and Success)

was renamed, and one factor (Healthcare Problems) did not emerge from the factor analysis. Scores for the four factors are summed to provide an overall GRCS score. Two subsequent studies of the specific psychometric properties of the GRCS have indicated support for O'Neil et al.'s (1986) revised four factor model of MGRC. Good et al. (1995) examined the GRCS, utilizing separate samples of 1,043 male undergraduates and 130 male university counseling center clients. Cronbach's α for the overall GRCS score ranged from .88 to .90, with Cronbach's α for the four factors ranging from .74 to .88. Convergent validity for the GRCS was demonstrated by the scale's strong positive correlations with established measures that tapped some of the same constructs inherent in MGRC. For example, the GRCS correlated well with the Brannon Masculinity Scale (Brannon & Juni, 1984), a measure of belief in traditional male gender roles. There was a strong correlation with the Fear-of-Intimacy Scale (Descutner & Thelen, 1991), a measure of anxiety about close interpersonal relationships. The GRCS also correlated well with the SCL-90-R (Derogatis, 1983), a measure of psychological symptoms and problems. Correlations with these measures indicated that subjects who had more MGRC believed more strongly in traditional male gender roles, had more anxiety about interpersonal relationships, and reported more psychological symptoms and problems. In addition, confirmatory factor analysis indicated that O'Neil's (1986) four factor model was the best fit for this sample. Rogers, Abbey-Hines, and Rando (1997), utilizing additional data from the Good et al. (1995) study, obtained Cronbach's α scores for the four factors that ranged from .79 to .88. Intercorrelations among the four factors ranged from .23 to .52. These scores indicated an improvement over Good et al.'s (1995)

statistical findings, and provided further support for use of the GRCS as a measure of MGRC.

MGRC and Psychological Well-Being: Emotional Component

Subsequent research has combined the GRCS with a variety of psychological measures to examine psychological well-being and help-seeking behaviors in men. For the purposes of this study, psychological well-being was defined as the extent to which individuals experienced problems with depression, anxiety, anger, and self-esteem, as well as their attitudes toward seeking professional psychological help. Increased depression, anxiety, and anger, along with lowered self-esteem and more negative attitudes toward psychological help-seeking, were assumed to be indicative of less psychological well-being.

It has become standard procedure, in research comparing the relationship between psychological well-being and male gender issues, to incorporate some measurement of one or more of the aforementioned constructs that define well-being (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Davis & Walsh, 1988; Good & Mintz, 1990; Good et al., 1996; Good & Wood, 1995; Heppner, 1995; Sharpe & Heppner, 1991; Sharpe, Heppner, & Dixon, 1995; Simonsen, Blazina, & Watkins, 2000). Following are summaries of some of these studies, each of which employed use of the GRCS to assess MGRC in men.

Good and Mintz (1990) found that, in a sample of 401 undergraduate males, all four factors of MGRC were strongly correlated with a measure of symptoms of clinical depression in the general population, the CES-D (Radloff, 1977). Subjects who acknowledged increased levels of depression also suffered from many of the problems

that characterize each of the four factors of MGRC. In a comparative study of 134 males, who were 48% White, 34% Black, and 15% Hispanic, Stillson, O'Neil, and Owen (1991) found no significant group differences based on subject's race/ethnicity on issues of MGRC.

In a sample of clinical subjects, Good et al. (1996) found strong support for their prediction that increased MGRC would correlate with increased levels of depression as measured by the SCL-90-R (Derogatis, 1983). They also found increased MGRC to be strongly correlated with more severe problems with psychological well-being, such as paranoia, psychoticism, and obsessive-compulsive behavior. Sharpe and Heppner (1991) expanded their operationalization of well-being to encompass sex role orientation, self-esteem, anxiety, depression, social intimacy, and relationship satisfaction. In their sample of 190 males, they found the following. Males with lower self-esteem reported higher levels of MGRC. Increased levels of anxiety and depression were correlated with higher levels of MGRC. Intimacy showed a strong negative correlation with MGRC. Subjects with higher levels of MGRC reported lower overall levels of intimacy in their interpersonal relationships. Sex role orientation was found to strongly correlate with one factor of MGRC. Men who most strongly endorsed a masculine sex role orientation also reported the most problems with Success, Power, and Competition behaviors characteristic of MGRC

Cournoyer and Mahalik (1995) conducted a comparative study of "college-aged" (ages 17-23) and "middle-aged" (ages 36-45) men with respect to MGRC. Based upon their belief that, ". . . middle age is a time when men express more feminine aspects of their personality than do younger men, [thus] middle age should also be a time in which

men's experience of conflict surrounding gender roles changes as well" (p. 12), the researchers theorized that, while MGRC would still exist for middle-aged men, the nature of the conflict would be different than that for college-aged men. Results supported this hypothesis. Middle-aged men were found to have significantly less MGRC about success, power, and competition than college-aged men, but were found to have significantly more MGRC than college-aged men about conflicts between work and family. Neither group differed with respect to restricted emotionality or affectionate behavior between men. With regard to more global measures of psychological well-being, subjects in both age groups who reported fewer problems with restricted emotionality also reported fewer problems with depression and anxiety, had higher self-esteem, and reported higher levels of intimacy in their interpersonal relationships.

Blazina and Watkins (1996) found significant relationships between depression, anxiety, and two elements of MGRC. Males who had problems with restricted emotionality and work and family conflicts also had problems with elevated levels of depression and anxiety, as well as problems with anger management and expression. In a sample of exclusively gay men, Simonsen, Blazina, and Watkins (2000) found significant relationships between MGRC and anger, anxiety, and depression. Subjects in this study with higher levels of MGRC also acknowledged more problems with anger management and expression, anxiety, and feelings of depression.

MGRC and Help-Seeking Behaviors: Behavioral Component

The relationship between MGRC and the emotional component of psychological well-being in men has been clearly identified and explored. Another area of intrigue to

social scientists interested in male gender issues has been the influence of MGRC on men's attitudes toward seeking professional psychological help.

Just as there exist significant disparities in healthcare and social behaviors between men and women, there are also distinct differences between the two sexes when it comes to seeking out professional psychological help. In general, males seek out psychological services at one-half to one-third the frequency of women. The source of this disparity is primarily rooted in rigid gender role socialization among men, and in American cultural ideas about the meaning of masculinity (Good, Dell, & Mintz, 1989; Good, Wallace, & Borst, 1994).

Traditional, rigid male gender role socialization and expectations about masculinity are simply inconsistent with behaviors necessary to derive benefit from psychological interventions. According to Good and Wood (1995), "[T]he requirements of being a 'good' client seem antithetical to traditional male gender roles. For example, recognition and acknowledgement of personal problems, willingness to self-disclose, tolerance of interpersonal vulnerability, and emotional awareness and expression are potentially desirable characteristics of counseling clients and yet are the direct opposite of the traditionally socialized male role" (p.70). These researchers, in a study of MGRC, depression, and attitudes toward help-seeking, also theorized that two primary factors underlie MGRC: Restriction-related MGRC and achievement-related MGRC. They described restriction-related MGRC as behaviors that have been traditionally discouraged for males (e.g., expressing feelings and emotions, having close interpersonal relationships with other men), and achievement-related MGRC as behaviors that have been traditionally encouraged for men (e.g., being successful, being high achieving). In their

sample of 397 undergraduate males, the researchers found that almost 25% of the variance in attitudes toward help-seeking was accounted for by restriction-related MGRC (i.e., men who endorsed higher levels of restriction-related MGRC had more negative attitudes about help-seeking), whereas achievement-related MGRC was unrelated to help seeking attitudes for this sample.

Good, Dell, and Mintz (1989) believed that attitudes related to power and control were inherent in decreased help-seeking among men with MGRC. They theorized that, “The nature of the therapeutic relationship may emphasize the power differential between the therapist and client. Thus, men may avoid entering therapy because of an aversion to being in an apparently subordinate role and hence failing to live up to the requirements of male power” (p.296). Among the 401 undergraduate males in their study, they found that subjects with less traditional beliefs about male gender roles had more positive attitudes about seeking out psychological help, and were in fact more likely to have sought out psychological help in the past, than those subjects with more traditional and rigid male gender role beliefs. Blazina and Watkins (1996) also found that men scoring higher on Success, Power, and Competition on the GRCS had the most negative attitudes about seeking psychological help.

Specific types of psychological interventions may be viewed differently by men with varying levels of MGRC. In a study of 164 undergraduate males, Wisch, Mahalik, Hayes, and Nutt (1995) found that specific variations in counseling techniques were indicative of attitudes about seeking out counseling. While all subjects who were higher in MGRC also expressed more negative attitudes about help-seeking, the researchers also found that an emotion-focused intervention was viewed more negatively than a cognitive-

focused intervention by those subjects with higher levels of MGRC. Subjects with lower levels of MGRC did not view either one of the interventions as more negative than the other.

Fisher and Good (1997) designed a study to determine, among other things, whether men with MGRC even had the necessary emotional skills to benefit from seeking psychological help. Results indicated that, among their subjects, there was no identified deficit in their ability to introspect and identify feelings. The problem was instead identified as a lack of willingness to do so. Men who had more MGRC as measured by the GRCS were significantly more likely to acknowledge that they were not willing to talk about their feelings, rather than being unable to talk about them.

Mahalik (1999) delineated a variety of reactions that interpersonal psychotherapy could be expected to elicit from men who experienced MGRC. These include: hostility, in which the client might attack the therapist for not providing a rapid solution to the client's presenting problems; coldness, in which the client might disregard the importance and relevance of both his own feelings and the feelings of others about his presenting problem; mistrust, in which the client, fearing that he may be misunderstood or misjudged, might not trust the therapist or the therapeutic process; competition, in which the client might go to great lengths to convince the therapist that others are the cause of the client's presenting problem; and dominance, in which the client might pressure the therapist into taking the client's preferred approach (or some other approach) to the client's presenting problem.

Gay Men and Psychological Well-Being

Gay men comprise a significant minority among all males in the United States. Alfred Kinsey's ground-breaking research in the 1940s on the sexual behavior of American males resulted in the commonly-cited statistic that 10% of the American population is homosexual. The actual data from the Kinsey study showed that 10% of respondents acknowledged being "more or less exclusively homosexual for at least three years between the ages of 16 and 55," whereas 4% acknowledged being "exclusively homosexual throughout their lives, after the onset of adolescence" (Kinsey, Pomeroy, & Martin, 1948, pp. 650-651). Additional data on the prevalence of homosexuality were derived from the National Health and Social Life Survey (NHSLs), published in 1994. The NHSLs, regarded as the most comprehensive and high quality survey of sexual behavior conducted in the United States to date, estimated that 5% of males had had a same-sex partner since attaining adulthood, 8% of males desired same-sex sexual contact, and 3% self-identified as homosexual (Laumann, Gagnon, & Michael, 1994). Summarizing 48 years' worth of research on sexual behavior that included estimates of the prevalence of homosexuality in the general population, Michaels (1996) found various estimates that ranged from a low of 1% to a high of 9.9% of the general population in the United States as being homosexual.

Regardless of the exact proportion of homosexual males in the general population, issues of importance to gay men have been underrepresented in counseling research in general (Atkinson & Hackett, as cited in Wisch & Mahalik, 1999), and in masculinity research in particular (Simonsen, 1999; Simonsen, Watkins, & Blazina, 2000). A disproportionate amount of the literature published since 1981 on psychological well-

being in gay men has focused rather narrowly on those gay men who are either HIV-positive or who have been diagnosed with AIDS. Most of the remaining literature in this area has focused on heterosexuals' perceptions of gay men, and how these perceptions may negatively affect, and contribute to the perpetuation of stereotypes about, gay men (Chung & Katayama, 1996; Shepard, 1999).

In one of the first comparative studies of psychological well-being in heterosexual and gay men, Siegelman (as cited in Harry, 1983) found no significant differences between the two groups on various measures of psychological well-being created specifically for the study, but found a significant within-group difference among the gay men. Greater levels of well-being, particularly self-esteem, were highly correlated with the self-report of more overtly masculine behaviors and personality traits among the gay men in that sample.

In a study examining self-esteem, depression, and self-perception of masculinity, Carlson and Steuer (1985) found that self-perceived masculinity was a strong predictor of self-esteem in gay men. In addition, self-perceived masculinity was also found to be a strong predictor of depression for this population. In both cases, gay men who perceived themselves as more masculine reported better self-esteem and lower levels of depression than gay men who perceived themselves as less masculine and more feminine. Compared to the gay men, the heterosexual men in the study also reported a strong relationship between masculinity and self-esteem (i.e., heterosexual men who perceived themselves as more masculine reported higher self-esteem), but masculinity was not significantly related to depression

In a comparative study of heterosexual and gay men, Harry (1983) found no significant differences between the two groups on measures of self-esteem or dominance, but did find that gay men reported significantly higher levels of femininity than heterosexual men, while simultaneously reporting significantly lower levels of competitiveness than heterosexual men.

Coyle (1993) also compared heterosexual and homosexual men on level of psychological well-being. Utilizing sexual orientation and marital status as independent variables, he found that gay men reported similar levels of well-being as those reported by heterosexual men who were divorced, separated, or widowed. Gay men reported significantly less well-being than single or married heterosexual men. The researcher concluded that gay men were comparable on well-being to heterosexual men who had experienced emotionally traumatic life events. He attributed this similarity to the fact that gay men must live in a world that, in general, is heterosexist and homophobic, instead of it being an indication that gay men are intrinsically worse off than heterosexual men with regard to psychological well-being.

In a study of well-being in gay men as it relates to MGRC, Simonsen, Blazina, and Watkins (2000) found strong correlations between three components of psychological well-being and the four elements of MGRC. Gay men with MGRC also reported significantly elevated levels of anger, anxiety, and depression. Although the sample in this study was solely comprised of gay men, the researchers found their results to be consistent with similar studies of well-being in which sexual orientation was not determined, and stressed the importance of the similarities between gay and non-gay men with regard to their experience of MGRC.

With respect to help-seeking behaviors in gay men, research in this area has focused on either similarity concerns in therapist selection among gay men (i.e., that the therapist that they select also be gay), or on issues of concern to gay men that non-gay therapists need to be aware of and about which they need to be knowledgeable (Chung & Katayama, 1996; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Shepard, 1999).

To date, only one study has been published that examines help-seeking behavior in gay men in relation to issues of MGRC (Simonsen, Blazina, & Watkins, 2000). This study found significant correlations between MGRC in gay men and attitudes toward seeking professional psychological help. Gay men who reported higher levels of restricted emotionality and restricted affectionate behavior (as measured by the GRCS) had significantly more negative attitudes about help-seeking than those subjects who did not report elevated levels of these two elements of MGRC. These findings were consistent with much of the previously cited research on the relationship between MGRC and help-seeking attitudes. The authors of this study also found that, compared to prior studies with (presumably) heterosexual males, this sample of gay males acknowledged significantly less restricted affectionate behavior between men.

On the opposite side of the help-seeking issue, Wisch and Mahalik (1999) examined male therapists' MGRC and attitudes toward homosexual therapy clients. They found an interesting bias toward either overpathologizing or underpathologizing, based on the level of the therapist's MGRC. Among the three different types of presenting problems of hypothetical therapy clients (anger, sadness, or emotional restriction), male therapists with higher MGRC rated angry gay male clients as significantly more

pathological than heterosexual male clients with the same presenting problems.

Conversely, male therapists with lower MGRC rated sad gay male clients as significantly less pathological than heterosexual male clients with the same presenting problems. The authors did note that, despite the overpathologizing bias among some male therapists, overall their study participants were more than one standard deviation below the mean MGRC scores among participants in seven prior studies on MGRC.

Purpose of Study

The relationship MGRC and psychological well-being in men has been clearly delineated here. Due in large part to prior social science research about gender differences, men have become increasingly aware of many of the aforementioned problematic gender role behaviors and expectations that have been brought about and imposed on them by the gender role socialization process. O'Neil (1981) summarized the issue well:

Men are also oppressed and restricted by rigid gender role socialization that limits their potential to be fully functioning and whole human beings. The belief that men are oppressed by sexism and rigid gender role socialization is difficult for many men to understand. Many men have been socialized to be sexist; their attitudes, values, and behaviors have never been challenged or analyzed. Many men have had difficulty developing and integrating new male roles compatible with nonsexist behavior and overcoming the restrictions of past socialization" (p. 205).

Despite the expansive (and continually growing) body of research into MGRC issues, two areas of this construct have been neglected. First, only one study has been

published (Simonsen, Blazina, & Watkins, 2000) that has focused on the experience of MGRC specifically in gay men. Second, no studies have been conducted that have utilized sexual orientation as a variable in comparing the experience of MGRC in heterosexual and homosexual men. This study, therefore, was designed to expand upon previous research into MGRC, and to examine how such conflict affects psychological well-being in men.

The prior research on well-being that has been summarized here has, with only one exception, made no distinction as to the sexual orientation of study participants. This study was designed to be comparative in nature, and examined how men in a homogeneous setting (i.e., a college campus) compared on MGRC and psychological well-being (specifically attitudes toward help-seeking, self-esteem, depression, anxiety, and anger), based upon their self-identified sexual orientation. This study also sought to replicate prior research (Stillson, O'Neil, & Owen, 1991) that found no significant relationship existed between race/ethnicity and MGRC, as well as prior research (Cournoyer & Mahalik, 1995; Davis & Walsh, 1988; Sharpe & Heppner, 1991) that found significant negative correlations between MGRC and self-esteem. It was hoped that results from this study would add to the continually expanding body of knowledge about men's issues in general and MGRC in particular, as well as providing useful information for mental health professionals who may encounter clients with MGRC.

Hypotheses and Research Questions

Given that this study appeared to be the first to compare, in a homogeneous sample, differences in MGRC based on sexual orientation, coupled with the fact that the number of published studies of MGRC in gay men is minute ($n = 1$), hypotheses were

limited. Based on a review of the research literature, the following hypotheses were postulated.

Hypothesis I. Men who endorsed higher levels of MGRC would exhibit more problems with psychological well-being, specifically increased anger, anxiety, depression, decreased self-esteem, and more negative attitudes toward psychological help-seeking, regardless of sexual orientation.

Hypothesis II. Gay men would endorse significantly lower levels of restricted affectionate behavior between men than would heterosexual males.

The following research questions were also addressed.

Research Question I. Would there be significant group differences between heterosexual and gay men with regard to problems with psychological well-being, specifically increased anger, anxiety, depression, decreased self-esteem, and more negative attitudes toward psychological help-seeking?

Research Question II. Would there be significant group differences between heterosexual and gay men on restricted emotionality, conflict between work and family relations, and success, power, and competition?

Research Question III. Would there be significant group differences based on subject's race/ethnicity with regard to MGRC?

CHAPTER 2

METHOD

Participants

Subjects for both the heterosexual and gay male samples (combined $n = 198$) were recruited from among volunteers in the undergraduate subject pool at the University of North Texas. In addition, subjects for both samples were recruited from among volunteers at the following campus-based student organizations at the University of North Texas:

- 1) Baptist Student Ministry Men's Group
- 2) College Democrats
- 3) College Republicans
- 4) Gay and Lesbian Association of Denton (formerly known as COURAGE)
- 5) Habitat for Humanity

The rationale for recruiting subjects from among these student organizations was to sample participants from a variety of social and political orientations. For the heterosexual men ($n=96$), subjects were obtained as follows. Approximately 51% came from the undergraduate subject pool, 22% came from the College Democrats, 13% came from the College Republicans, 10% came from the Baptist Student Ministry, and 4% came from Habitat for Humanity. For the gay men ($n=102$), approximately 75% came from COURAGE/Gay and Lesbian Association, 12% came from the undergraduate subject pool, and the remaining 13% came from the remaining student groups. It was

impossible to determine exactly what groups the remaining 13% of gay men came from, due to missing source identification codes on those questionnaires. Unfortunately, this missing information makes it unclear as to whether this researcher's goal (i.e., to sample participants from a variety of social and political organizations) was effectively achieved.

Subjects were recruited both by direct, personal appeal from this researcher, as well as by appeals from de facto research assistants. Informed consent was documented with a cover letter (see Appendix A), which participants kept. Subjects were surveyed in groups ranging in size from three to twenty, and hand-wrote their responses on each questionnaire that comprised the survey packet. The packets typically took from 30 to 45 minutes to complete

The sexual orientation of participants in this study was determined by subjects' self-report. Subjects were asked to identify their sexual orientation as “heterosexual,” “bisexual,” or “homosexual.” Chung and Katayama (1996) conducted an extensive content analysis on 144 empirical studies published from 1974-1993 that included lesbian/gay/bisexual subjects, and determined that self-identification of subjects' sexual orientation was the most commonly utilized method in studies of lesbian/gay/bisexual issues. Self-identification of subjects' sexual orientation was also successfully employed in the one published study of MGRC in gay men (Simonsen, Blazina, & Watkins, 2000). Subjects who self-identified as bisexual had their questionnaires thrown out.

A total of 101 questionnaires was distributed for the heterosexual sample. Of these, five questionnaires were unusable due to either lack of completion or an obvious response set, for a total of 96 useable questionnaires. Mean age of the heterosexual sample was 19.7 years ($SD = 1.8$), with a range from 18 to 26 years. Sixty-seven percent

of the sample ($n = 64$) was White, 18% ($n = 17$) was Black, 9% ($n = 9$) was Hispanic, 4% ($n = 4$) was Asian/Pacific Islander, and 2% ($n = 2$) was Native American. None of the subjects in the heterosexual sample indicated they were Biracial/Multiracial. Additional demographic data for the sample are presented in Table 1.

A total of 115 questionnaires was distributed for the gay sample. Of these, 13 questionnaires were unusable due to either lack of completion or self-identification of the subject as bisexual, for a total of 102 useable questionnaires. Mean age of the gay sample was 20.5 years ($SD = 2.0$), with a range from 18 to 26 years. Sixty-six percent of the sample ($n = 68$) was White, 17% ($n = 17$) was Hispanic, 11% ($n = 11$) was Biracial/Multiracial, and 6% ($n = 6$) was Black. None of the subjects in the gay sample indicated they were Asian/Pacific Islander or Native American. Additional demographic data for the sample are presented in Table 1.

On the Demographic Questionnaire, one of the options for "Religion" was "Other," with a blank space for subjects to hand write the name of their religion. The idea here was for subjects who felt their religion could not be classified as "Catholic," "Jewish," or Protestant" to be able to more accurately identify their religious affiliation. However, a number of subjects in both samples checked "Other" for their religion, then hand wrote the name of a mainstream Protestant denomination (e.g., Methodist, Baptist) in the blank space. This indicates an apparent misunderstanding of religious nomenclature for a number of subjects. The responses in question were therefore manually recoded to reflect the correct classification for "Religion."

Measures

Demographic Questionnaire. A demographic questionnaire was administered to study participants. This questionnaire was designed to elicit general information about participants, such as age, race/ethnicity, sexual orientation, religion, beliefs, etc. (see Appendix A).

Gender Role Conflict Scale (GRCS; O'Neil, et al., 1986). To obtain a measure of MGRC, the GRCS was administered. The GRCS is a pencil-and-paper task that contains 37 statements concerning thoughts and feelings regarding male gender role behaviors. Subjects report the extent to which they agree or disagree with each statement on a 6-point, bipolar, Likert-type scale, with responses ranging from "strongly agree" to "strongly disagree." The GRCS provides scores on each of four subscales: Success, Power, and Competition; Restricted Emotionality; Restricted Affectionate Behavior Between Men; and Conflict Between Work and Family. Subscale scores are obtained by summing the responses to questions that load on each scale. Higher scores are indicative of more MGRC. Internal consistency reliability (Cronbach's α) values ranging from .75 to .88 have been reported for the GRCS. Four-week test-retest reliability values have ranged from .72 to .86 (see Appendix A).

Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). To obtain a measure of general psychological symptoms and problems, the HSCL was administered. The HSCL is a paper-and-pencil task that ask subjects to rate how much they have been bothered by a variety of symptoms over the preceding two weeks. Subjects rate their responses on a continuum from "not at all" to "extremely." Of specific interest for this study were questions about symptoms of anger, anxiety, and depression. Chronbach's α for the content areas of anger, anxiety, and depression has

been reported at .85, .84, and .86, respectively. Test-retest reliabilities for the three content areas of specific interest range from .75 to .81. Higher scores in each of the three content areas indicate more problems with anger, anxiety, and depression. The HSCL has been effectively utilized in previous research relating psychological symptoms and problems to MGRC (Selby, 1999; Simonsen, Blazina, & Watkins, in press) (see Appendix A).

Rosenberg Self-Esteem Scale. To obtain a measure of self-esteem, the Rosenberg Self-Esteem Scale (RSE; Rosenberg, as cited in Blascovich & Tomaka, 1991) was administered. The RSE is a paper-and-pencil task that contains 10 statements about how individuals feel about themselves, and was designed to be a global measure of self-worth or self-acceptance. Responses are rated on a 4-point, bipolar, Likert-type scale, ranging from “strongly disagree” to “strongly agree.” Cronbach’s α scores ranging from .77 to .88 have been obtained for the RSE; one to two week test-retest reliability scores ranging from .82 to .85 have been reported as well. The scoring direction for 5 of the 10 items on the RSE is reversed in an attempt to eliminate response set distortion, such as yea-saying. Higher scores on the RSE are indicative of a higher level of feeling of self-worth and self-acceptance (see Appendix A).

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fisher & Turner, 1970). To obtain a measure of attitudes toward help-seeking, the ATSPPH was administered. The ATSPPH is a paper-and-pencil task that contains 29 items about a subject's general orientation toward seeking professional help for psychological problems. Responses are rated on a 4-point, bipolar, Likert-type scale, ranging from "strongly disagree" to "strongly agree." Higher scores on the ARSPPH

indicate more positive attitudes toward help-seeking. Cronbach's α values ranging from .83 to .86 have been obtained for the ATSPPH, with 6-week test-reliability values ranging from .82 to .86. The scoring direction for 17 of the 29 items is reversed in an attempt to eliminate response set distortion, such as yea-saying. For the purposes of this study, the word "psychiatrist" on the ATSPPH was replaced with the word "psychologist" (see Appendix A).

Design

Alpha levels for all statistical analyses in this study were set at the .05 significance level. Effect sizes were determined based on the results of Blazina and Watkins (1996), Selby (1999), and Simonsen, Blazina, and Watkins (2000). The focus of these three studies was MGRC; effect sizes ranged from .25 to .40 for basic correlations, and from .40 to .48 for canonical correlations, utilizing similar instruments and statistical guidelines. Based on a preestablished power level of .80, it was determined that a subject pool from 45-85 subjects per group (i.e., heterosexual males and gay males) would be necessary to obtain statistically significant results (Rosenthal & Rosnow, 1991). For this study, it was decided that a minimum sample of 85 subjects per group would be obtained. regard to MGRC?

CHAPTER 3

RESULTS

The data obtained as a result of this study were subjected to a variety of statistical analyses to identify relationships among variables, as well as differences between the two sample groups.

Descriptive Statistics

Descriptive statistics were calculated for all variables measured, including means, standard deviations, skew, and kurtosis. Demographic data for both sample groups are summarized in Table 1. Descriptive data for the MGRC variables and psychological well-being variables are summarized in Table 2. Skew and kurtosis for all variables measured were within acceptable limits.

Reliability data for the scales were as follows. Internal consistency reliability for the ATSPPH scale was in the moderate range (Cronbach's $\alpha = .77$). For the GRCS variables, reliability was .75 for the CWF subscale, .73 for the RAB subscale, .73 for the RE subscale, and .87 for the SPC subscale. For the HSCL variables, reliability was .80 for the ANG subscale, .82 for the ANX subscale, and .84 for the DEP subscale. Reliability for the RSE scale was in the moderate-to-high range (Cronbach's $\alpha = .83$).

Data Analysis

Canonical correlation analysis was used to examine the relationships between two different sets of variables. A multivariate procedure, canonical analysis allows for the examination of correlations among multiple predictor variables and multiple criterion

variables. This is in contrast to multiple correlation analysis, which examines the relationship of a set of two or more variables with a single variable. The canonical procedure was created in response to criticism that analysis of such univariate correlations likely oversimplified what could actually be a highly complex set of relationships among variables (Thorndike, 1978). Canonical analysis reduces the likelihood of Type I error, a problem inherent in the analysis of numerous univariate correlations (Good, Dell, & Mintz, 1989). For this study, canonical analysis was utilized to examine the relationship between MGRC, as measured by the four subscales of the GRCS, and psychological well-being, as measured by the ATSPPH scale, the three subscales of the HSCL, and the RSE scale.

A correlation matrix was constructed to identify relationships among the GRCS subscale scores, the ATSPPH score, the HSCL subscale scores, the RSE score, and demographic data. T-tests were utilized on all continuous variables to examine between-group differences with the heterosexual men and gay men.

Associations Among Variables

The maximum number of canonical correlations produced is equal to the number of variables in the smaller of the two variable sets. For the sake of simplicity, we will refer to the variable sets as the MGRC set (comprised of the CWF, RAB, RE and SPC variables), and the Well-Being set (comprised of the ATSPPH, ANG, ANX, DEP, and RSE variables). Since the smaller of the two variable sets (the MGRC set) is comprised of four variables, this is the number of canonical correlations that was produced.

Analysis of results from the sample of heterosexual men revealed that only two of the four canonical correlations produced were significant. The first canonical root

produced a correlation of .49, $F(5,90) = 2.59$, $p < .001$. Squaring the canonical correlation produces the amount of variance in one variate that can be predicted from its paired variate. Squaring this first canonical correlation revealed that 24.9% of the variance in one variate could be predicted by its paired variate. The second canonical root produced a correlation of .42, $F(5,90) = 2.02$, $p < .025$. Squaring this second canonical correlation revealed that 17.7% of the variance in one variate could be predicted by its paired variate. The standardized (i.e., Z-transformed) canonical coefficients indicate that in the first canonical root, RE and CWF were the most heavily weighted variables in the MGRC set, while ASPPH and RSE were the most heavily weighted variables in the Well-Being set. In the second canonical root, the standardized canonical coefficients indicate that CWF and RE were the most heavily weighted variables in the MGRC set, while ASPPH and DEP were the most heavily weighted variables in the Well-Being set. According to Thompson (1984), a general rule of thumb in canonical analysis is to consider only those variables having a correlation above 0.30 to be part of the canonical variable. With a cutoff of 0.30, three of the four variables in the MGRC set were found to correlate with the first canonical variate. All five of the variables in the Well-Being set were found to correlate with the first canonical variate. This first pair of canonical variates indicates that heterosexual men with higher CWF (.64), higher RE (.77) and higher SPC (.44) also reported lower (i.e., more negative) ASPPH (-.69), higher ANG (.66), higher ANX (.571), higher DEP (.71), and lower RSE (-.76). The second pair of canonical variates indicates that heterosexual men with higher CWF (.71) and lower RE (-.51) also reported higher (i.e., more positive) ASPPH (.68), higher ANG (.51), higher

ANX (.38), higher DEP (.52), and lower RSE (-.32). These data are summarized in Table 3.

Analysis of results from the sample of gay men likewise revealed that only two of the four canonical correlations produced were significant. The first canonical root produced a correlation of .88, $F(5,96) = 17.53$, $p < .001$. Squaring this first canonical correlation revealed that 78.6% of the variance in one variate could be predicted by its paired variate. The second canonical root produced a correlation of .75, $F(5,96) = 9.19$, $p < .001$. Squaring this second canonical correlation revealed that 57.3% of the variance in one variate could be predicted by its paired variate. The standardized (Z-transformed) canonical coefficients indicate that in the first canonical root, RAB and SPC were the most heavily weighted variables in the MGRC set, while RSE and ANX were the most heavily weighted variables in the Well-Being set. In the second canonical root, the standardized canonical coefficients indicate that RE was the most heavily weighted variable in the MGRC set, while ANG and DEP were the most heavily weighted variables in the Well-Being set. With the aforementioned correlation cutoff set at .030, two of the four variables in the MGRC set were found to correlate with the first canonical variate. Four of the five variables in the Well-Being set were found to correlate with the first canonical variate. This first pair of canonical variates indicates that gay men with lower RAB (-.82) and lower SPC (-.79) also reported lower (i.e., more negative) ASPPH (-.38), lower ANG (-.45), and higher RSE (.72). The second pair of canonical variates indicates that gay men with higher RAB (.33) and higher RE (.97) also reported higher ANG (.47), higher ANX (.79), higher DEP (.85), and lower RSE (-.58). These data are summarized in Table 4.

Canonical redundancy analysis was conducted on the two sets of canonical correlations. This type of analysis provides a measure of how much variance in one set of variables can be predicted by the other set of variables. For the heterosexual men, the MGRC variables were found to predict 7.6% of the variance in the Well-Being variables. Conversely, the Well-Being variables were found to predict 11.6% of the variance in the MGRC variables. For the gay men, the MGRC variables were found to predict 27.1% of the variance in the Well-Being variables. Conversely, the Well-Being variables were found to predict 15.1% of the variance in the MGRC variables.

Correlation matrices for each sample were constructed to summarize relationships among all continuous variables measured; these matrices revealed a few significant relationships between gay mens' age and other variables utilized in the canonical correlation. The correlation matrix for the heterosexual male sample is presented in Table 5, while the matrix for the gay male sample is presented in Table 6.

Chi-square analysis and t-tests were utilized to examine the relationship between discrete demographic variables and continuous MGRC and well-being variables.

Analysis of the association between race/ethnicity and the four components of MGRC revealed one significant relationship. For the gay men, SPC and race/ethnicity were found to be related, $\chi^2(42) = 19.82, p < .001$, where Black gay men reported the highest levels of SPC ($M = 64.04$), followed by Hispanic ($M = 60.67$), White ($M = 48.91$), and Biracial gay men ($M = 39.53$). No other component of MGRC was found to be related to race/ethnicity for the gay men. None of the MGRC components were related to race/ethnicity for the heterosexual men. Attitudes toward psychological help-seeking (as measured by ASPPH scale scores) were related to religion for the gay men, $\chi^2(39) =$

14.49, $p < .001$. Among the different categories of religion, Catholic gay men had the most positive attitudes about seeking psychological help ($M = 80.01$), followed by gay men who listed their religion as "Other" ($M = 77.92$), "None" ($M = 75.83$), and "Protestant" ($M = 71.53$). Race/Ethnicity was related to problems with anger for the gay men, $\chi^2(30) = 15.04$, $p < .001$. Hispanic gay men reported the highest levels of anger ($M = 18.10$), followed by White ($M = 13.27$), Black ($M = 11.29$), and Biracial/Multiracial gay men ($M = 8.35$). For the heterosexual men, only one relationship was found between demographic variables and MGRC variables. Race/Ethnicity and problems with restrictive emotional expression were found to be related, $\chi^2(160) = 7.92$, $p < .01$. Heterosexual men who self-identified as Asian/Pacific Islander reported the highest levels of RE ($M = 41.54$), followed by Hispanic ($M = 34.78$), Black ($M = 32.35$), White ($M = 29.17$), and Native American ($M = 19.50$) heterosexual men. The chi-square test was utilized in the above-referenced comparisons because the ANOVA originally employed contained a major violation of one of its primary assumptions (i.e., equal sample size among cells). A minimum of 88% of the cells in all the chi-square contingency tables referenced above had an expected n of less than five, calling in to question both the statistical power and the generalizability of these findings. There were some significant relationships found between relationship status and some MGRC and well-being variables for the gay men. To increase the statistical power of these comparisons, the relationship categories of "married/in a monogamous relationship" and "in a non-monogamous relationship" were combined into one category simply titled "in a relationship." The following comparisons utilize the recoded data. Gay men who were single ($M = 32.67$) reported significantly more RE, $t(100) = 5.54$, $p < .001$, than gay men

in a relationship. Single gay men ($M = 13.8$) also reported significantly more anger, $t(100) = 2.88, p < .01$, than gay men in a relationship ($M = 10.48$). Anxiety was lower ($M = 7.52$) for gay men in a relationship, $t(100) = 3.18, p < .01$, than for single gay men ($M = 10.93$). Gay men who were single ($M = 19.33$) reported substantially more depression, $t(100) = 5.20, p < .001$, than gay men in a relationship ($M = 11.15$). Finally, gay men in a relationship ($M = 36.41$) reported significantly higher self-esteem, $t(100) = 3.39, p < .001$, than gay men who were single ($M = 31.47$).

T-tests were utilized on all continuous variables to identify between-group differences in the two samples. There was a significant group difference for RAB, $t(196) = 3.26, p < .0025$, wherein heterosexual men ($M = 27.2$) reported significantly higher RAB than did gay men ($M = 24.0$). There were no between-group differences on any of the other continuous variables measured in the study. To further analyze the differences between heterosexual and gay men on RAB, t-tests were conducted on the eight questions that comprise the RAB subscale of the GRCS. There were statistically significant differences between the two samples on all eight questions, although not all differences were in the expected direction. On three of the questions, the mean score for gay men was actually higher (indicating more RAB) than for heterosexual men. Data on the differences between the two samples on the RAB subscale items are summarized in Table 7.

regard to MGRC?

CHAPTER 4

DISCUSSION

There were two primary goals for this study. Given that the concept of MGRC in gay men has been sorely neglected in prior masculinity research, one goal of the study was to further explore how issues related to MGRC affect the psychological well-being of gay men. Since the concept of MGRC in gay men is poorly researched and not particularly well understood, it was important to identify what variables might influence the relationship between traditional male role expectations and stereotypes and psychological well-being in gay men. Another goal of the study was to examine the similarities and differences in how MGRC affects the psychological well-being of both heterosexual and gay men who are drawn from a homogeneous setting (i.e., a college campus). The subsequent findings that were motivated by these goals will now be examined in some detail, both with respect to specific hypotheses and research questions posed by the study, as well as implications for future research.

The first hypothesis proposed by the study was that men who endorse higher levels of MGRC will exhibit more problems with psychological well-being, specifically increased anger, anxiety, depression, decreased self-esteem, and more negative attitudes toward psychological help-seeking, regardless of sexual orientation. This hypothesis was supported by the results for both groups of men, although the specific patterns by which MGRC and well-being interacted were somewhat different for the two groups.

MGRC and Well-Being in Gay Men

Examination of the first canonical root for the sample of gay men revealed that those subjects who reported less concern about showing affectionate behavior with other men, as well as less concern about success, power, and competition, also reported having higher self-esteem, less anger, and more negative attitudes toward help-seeking. The finding here about help-seeking was unexpected. It would seem logical to expect that, as problems with MGRC began to decrease, all aspects of well-being, including attitudes toward help-seeking, would improve. However, this contrary finding highlights just how complex the relationship seems to be between traditional male gender roles and psychological well-being. Perhaps the gay men in this study, in viewing themselves as having fewer problems with traditional male gender roles, might have seen themselves as being less in need of any sort of psychological help. The well-being factor of self-esteem may have played a role here as well; gay men with higher self-esteem may have seen less need for outside help with psychological problems. The gay men in the Simonsen (1999) study also had more negative attitudes toward help-seeking, but this was as problems with MGRC went up, not down. Blazina and Watkins (1996) and Good, Dell, and Mintz (1989) also found among their subjects that attitudes toward help-seeking became more positive as problems with MGRC decreased. An alternative hypothesis for the gay men in the present study is that this finding represents a somewhat defensive attitude about the need to seek help in the first place. Perhaps for these gay men, there is an underlying defensiveness about being gay, such that being gay is a problem in and of itself. So the need to seek out psychological help, regardless of the real reason for needing such help, might have been seen as a validation that there is, in fact, a problem with being gay. This

possible defensiveness subsequently could have impaired the willingness to seek help. Regardless of why this might have occurred, this anomalous finding may warrant further investigation in the future.

Examination of the second canonical root for the gay men revealed that those subjects who reported more restricted emotional expression also reported more anger, more anxiety, more depression, and lower self-esteem. Here, the relationship between the traditional male gender role of restricted emotional expression and well-being seems more clear cut. This finding suggests that gay men who feel they have less freedom in their ability to self-disclose thus suffer from more problems with emotional well-being, and have a poorer sense of self-worth than gay men for whom self-disclosure is less problematic. This finding is partly consistent with Simonsen (1999), who found all four factors of MGRC to be related to problems with anger, anxiety, and depression.

MGRC and Well-Being in Heterosexual Men

Examination of the first canonical root for the sample of heterosexual men revealed that those subjects who reported more problems with restricted emotional expression, more concern about showing affectionate behavior with other men, and more concerns about success, power, and competition with other men, also reported increased anger, increased anxiety, increased depression, lower self-esteem, and more negative attitudes about help-seeking. These findings are consistent with prior research on how psychological well-being suffers from the influence of rigid, traditional male role expectations. For example, Sharpe and Heppner (1991), in their study of college-age men, found similar results of increased MGRC being related to decreased self-esteem, anxiety, and depression, as did Cournoyer and Mahalik (1995), who more specifically

found that restricted emotional expression among college-age men was related to more problems with anxiety and depression, and lower self-esteem.

Examination of the second canonical root for the heterosexual men revealed that those subjects who reported more concerns about feeling conflicted between work and family life, as well as fewer problems with restricted emotional expression, reported more problems with anger, anxiety, and depression, and lower self-esteem, but more positive attitudes toward seeking psychological help. The relationship implied between attitudes toward help-seeking and restricted emotional expression seems logical, given that success in psychotherapy, across a broad range of theoretical approaches, is highly dependent on one's ability to introspect and emote effectively (Anchin & Kiesler, 1982). This finding suggests that heterosexual men who have fewer concerns about expressing their feelings to others would be more willing to express those feelings to a mental health professional.

The relationship implied between work and family conflict and decreased well-being (as measured by anger, anxiety, depression, and low self-esteem) seems logical, and is partly consistent with the findings of other studies of college-age men (e.g., Selby, 1999) that also found conflicted feelings about work and family to be related to increased problems with anger, anxiety, and depression. Perhaps these heterosexual men, recognizing the impact of competing demands between work and family, are also aware that they would be more willing to seek help from a mental health professional to deal with such competing demands.

Between-Groups Differences and Similarities

When examining how the two groups differed with respect to MGRC and well-being, it is interesting to note that the CWF variable was neither heavily weighted nor

strongly correlated in either canonical root for the sample of gay men, while this variable was among the mostly heavily weighted and strongly correlated variates in the sample of heterosexual men. Is it fair to assume that conflicted feelings about work and family were more salient for the heterosexual men than for the gay men in this study? This seems reasonable, given that 32% of the heterosexual men reported being in some type of relationship, whereas only 12% of the gay men reported being in a relationship. The difference in mean CWF scores for the two groups, however, was almost nonexistent (see Table 2). Also, since employment status was not a measured variable in this study, no determination could be made as to whether job responsibilities could be linked to relationship problems.

The second hypothesis proposed by this study was that gay men would endorse significantly lower levels of restricted affectionate behavior between men than would heterosexual males. This hypothesis was strongly supported by the data, which found that gay men did, in fact, report significantly less RAB than did heterosexual men. Demonstrating affection and concern for other men is inherent in gay men's emotional and sexual relationships with each other, so it would seem reasonable that gay men would report fewer problems with such expressions than would heterosexual men. When examining the individuals questions that comprise the RAB subscale of the MGRC scale, some interesting differences emerged between the heterosexual and gay men. On three of the questions on the RAB subscale ("Expressing my emotions to other men is risky," "I am sometimes hesitant to show my affection to men because of how others might perceive me," and "Men who are overly friendly to me make me wonder about their sexual preference"), gay men had higher mean scores, indicating they were actually

reporting more RAB than were the heterosexual men. The difference observed on these three items may not actually be an issue of MGRC, but rather an issue of attribution. Many gay men have a well-developed capability for detecting subtle verbal and non-verbal cues that aid in identifying each other, an ability referred to as "gaydar" in the vernacular of gay men (Cabaj & Stein, 1996; D'Emilio, 1998; Shepard, 1999). But "gaydar" is not infallible, and making an attribution of homosexuality to someone who is actually heterosexual could be embarrassing at best and potentially dangerous. So it is possible that the unexpected differences in these few RAB questions were the result of thoughts by the gay men about the potential consequences and sanctions inherent in making such a misattribution.

The first research question proposed by this study asked if there might be significant group differences between heterosexual and gay men with regard to problems with psychological well-being, specifically increased anger, anxiety, depression, decreased self-esteem, and more negative attitudes toward psychological help-seeking? The data indicate that there were, in fact, no significant group differences on any of the psychological well-being variables. In fact, given the range of possible scores on the well-being variables, some of the differences in mean scores between the groups were almost nonexistent. In other words, the gay men in this study appeared no more pathological than did the heterosexual men when it came to psychological well-being variables. Harry (1983) reported similar findings when comparing heterosexual and gay men on self-esteem and dominance, and actually found gay men to report fewer problems with competitiveness than heterosexual men. Since that particular study likely took place

before the AIDS crisis was in full swing, it provides no indication of how the well-being of gay men with AIDS might have been affected in comparison to heterosexual men.

Coyle (1993) found very different results, when the gay men in his study reported significantly less well-being than single or married heterosexual men. In the present study, marital status and sexual orientation were found to be unrelated to well-being, providing further support for the notion that the gay men in this sample had no more problems with psychological well-being than did the heterosexual men.

The second research question proposed by this study asked if there might be significant group differences between the heterosexual and gay men on the other three components of MGRC (i.e., restricted emotionality, conflict between work and family relations, and success, power, and competition). The data indicate that there were no significant groups differences on these remaining three factors. This implies that heterosexual men were no more pathological than gay men with respect to these other factors of MGRC. However, MGRC, by its very nature, is pathological, and indicates problems with rigid gender role socialization. It has been clearly established that both populations, regardless of sexual orientation, reported some problems with MGRC and resulting problems with well-being. It does appear, however, that when comparing the variables that comprise MGRC, the two groups differ significantly only on RAB.

The final research question proposed by this study asked if there might be significant group differences based on subjects' race/ethnicity with regard to MGRC. For the heterosexual men, there was no significant relationship found between race/ethnicity and MGRC. For the gay men, a significant relationship was found for the SPC factor of MGRC. Black and Hispanic gay men reported substantially more problems with SPC

than did White gay men, with Biracial gay men reporting the lowest levels of SPC. Given the historical mistreatment of minorities in general (Dana, 1983), as well as the mistreatment of gay men, in particular since the advent of the AIDS crisis (Klassen, Williams, & Levitt, 1989), it does not seem unreasonable to assume that minority gay men might feel they have to work harder and compete more to prove their worthiness in a homophobic minority subculture that mirrors the dominant heterosexual culture, as well as a racist gay community that mirrors the dominant Anglo culture. The present study's findings with regard to race differ from those of Stillson, O'Neil, and Owen (1991), who didn't find any indication that race impacted (presumably heterosexual) men's experience of MGRC. In the present study, the nonsignificant findings with respect to race/ethnicity and MGRC for the heterosexual men may have been due, in part, to the relatively low number of minorities in the study. On the other hand, there may well have been no relationship between these two factors for the heterosexual men.

Within-Group Differences

The correlation matrices constructed for each group revealed a few significant relationships for the gay men. Age and SPC were negatively correlated for the gay men, suggesting that the gay men in this sample worry less about issues of success, power, and competition as they get older. This finding is consistent with Cournoyer and Mahalik (1995), who found older men to be less conflicted about issues with SPC. Their study was of presumably heterosexual men, however, and did not examine differences in MGRC based on sexual orientation. Simonsen (1999) did not report any relationship between MGRC and age in his study of gay men and MGRC. In the present study, age was found to be positively correlated with attitude toward psychological help-seeking,

where gay men reported more positive attitudes about seeking psychological help as they got older. The relationship here was relatively strong, with the two variables sharing approximately 34% of their variability. Only two studies on MGRC could be found that looked at subjects' age as a variable (Cournoyer & Mahalik, 1995; Stillson, O'Neil, & Owen, 1991), and neither of these studies specifically looked at attitudes toward psychological help-seeking. Speculatively, the gay men in this sample may have a more relaxed attitude about acknowledging and discussing problems with well-being as they get older and begin to recognize the toll such problems may be taking on their level of functionality. Such awareness may come about as the result of years of experience with hostility from a disapproving dominant culture, experiences that have traditionally resulted in a higher incidence of emotional distress among gay men (Milton & Coyle, 1999). Consistent with this, age was also found to be positively correlated with anxiety for the gay men, such that they reported increased levels of anxiety as they got older. Similar findings were reported by Jones and Gabriel (1999), who found anxiety to be a more common presenting problem among gay men being seen for psychotherapy. Cournoyer and Mahalik (1995), however, found just the opposite results for (presumably) heterosexual men; the men in their study reported decreased problems with anxiety as they got older. The findings in the present study suggest a unique experience for gay men with regard to anxiety. This may be in large part due to the "culture of youth" in the gay community, which emphasizes youthful appearance and vitality, sometimes to the exclusion of all other attributes. For a number of younger gay men, attaining age 30 marks a milestone after which one can no longer call oneself "young" (Cabaj & Stein, 1996; Garnets, et al., 1991). The positive correlation of age and anxiety may be an indication

that the gay men in this study, young as they were with an average age of 20.5 years, already recognized the aforementioned, well-established liability that accompanies aging in the gay community (Jones & Gabriel, 1999; Kooden & Flowers, 2000; Milton & Coyle, 1999). What, if any, other problems may underlie this increase in anxiety as gay men age may be a topic for future investigation. Age was not found to correlate significantly with any of the MGRC or psychological well-being variables for the heterosexual men.

The chi-square analyses revealed some relationships of interest among demographic variables and some of the MGRC and well-being variables. Because the statistical power of the chi-square analyses was not particularly strong, these findings must be interpreted with caution and may not be generalizable. Among the relationships identified were the following. For the gay men, those who identified their religion as Catholic reported the most positive attitudes about seeking psychological help, while those gay men who identified their religion as Protestant had the most negative attitudes about help seeking. The positive attitudes toward help seeking observed among Catholic gay men make sense when one considers that Catholic liturgy requires individuals to seek out the help of an intermediary (i.e., a priest) to be absolved of their sins through confession. Plante (1999) actually likened the confessional process to psychotherapy, and postulated that many troubled individuals may find the type of absolution in therapy that has traditionally been experienced in confession. Therefore, Catholic gay men may simply be more at ease with discussing problems and conflicts with another person, especially if they think of that person as an authority who can absolve them of those problems and conflicts. In the same article, Plante (1999) also discusses the contentious

history of psychology and religion, and notes the strained relationship that still exists between psychology and many mainstream religions, including Protestant faiths. This strained relationship may partly explain why Protestant gay men had more negative attitudes about help-seeking. As a group, the gay men in this study had notably more negative attitudes overall ($\underline{M} = 77.76$, $\underline{SD} = 10.07$) about seeking psychological help than the gay men in the Simonsen (1999) study ($\underline{M} = 87.79$, $\underline{SD} = 10.49$). There are likely both education level and effects responsible for the differences noted, as the men in the Simonsen (1999) study were substantially older ($\underline{M} = 37$ years) than the gay men in this study ($\underline{M} = 20.5$ years), and more highly educated (59% college graduates versus 0% college graduates, respectively). This finding is also consistent with the previous discussion here about older gay men having a more relaxed attitude about help-seeking. The fact that more highly educated gay men are more likely to seek out psychological services is well supported in the research literature (Cabaj & Stein, 1996; Garnets, et al., 1991; Jones & Gabriel, 1999). There was also a relationship noted between race/ethnicity and problems with anger for the gay men. Hispanic gay men reported substantially higher levels of anger than White and Black gay men, with Biracial/Multiracial gay men reporting the lowest levels of anger. Perhaps Hispanics, who comprised the largest minority group among the gay men, reported higher levels of anger due to the problems and discrimination they encounter as a "double minority" (i.e., both racial and sexual orientation), although this phenomenon is typically more problematic for African-Americans than for any other racial or ethnic minority group (Klassen, Williams, & Levitt, 1989). What factors may underlie the difference in anger among minority gay men

may bear further investigation (not to mention stronger statistical power for analysis of data).

For the heterosexual men, race/ethnicity and restrictive emotional expression were related. Asian/Pacific Islander men reported the highest levels of RE, with Black and White men reporting somewhat lower levels, and Native American men reporting substantially lower levels. This finding is partly consistent with the issues presented in Dana (1993), who discussed the problems with restrictive emotional expression commonly seen among Asians. Interestingly, Stillson, O'Neil, and Owen (1991) found that Black, Hispanic, and White men, respectively, had the most problems in their study with RE, while RE was not seen to be a significant problem for Asian men; Native American men were not sampled in that study.

It was interesting to note some of the between-group differences among the gay men based on their relationship status. Gay men who were single, in comparison to those who were in some sort of relationship, reported significantly more problems with restricted emotional expression, anger, anxiety, and depression, and significantly lower self-esteem. It can be speculated that gay men in this sample draw strength from being in a relationship and therefore suffer from fewer problems with psychological well-being. It is also reasonable to assume that the ability to successfully maintain a relationship depends, in part, on one's ability to communicate openly with one's partner, thus the finding that RE was significantly lower for gay men in a relationship. There is some support for both of these assumptions in the research literature on gay relationships. Patterson (2000), in summarizing a decade's worth of social science research on same-sex relationships, reported that gays and lesbians who were coupled in a relationship were

consistently found to be more healthy, both physically and emotionally, than were gay and lesbian singles. It must also be acknowledged, however, that only 12% of the gay men reported being in a relationship, so generalizability of these findings is probably limited. These findings bear further investigation. Despite the fact that 32% of the heterosexual men reported being in a relationship, there were no significant links identified between relationship status and MGRC or well-being variables for them.

This is at odds with a considerable body of research on well-being and relationship status in heterosexual men. A number of recent studies (Epperly & Moore, 2000; Horwitz & White, 1998; Lee & Robbins, 2000) have added support to the already large body of research that shows heterosexual men who are in a relationship report significantly better well-being, both physical and emotional, than do single men. Perhaps for the heterosexual men in this sample, however, there is an age effect that influences their not having a greater sense of well-being from being in a relationship. There is some indication from prior research (e.g., Conger, Cui, Bryant, & Elder, 2000; Horwitz & White, 1998) that at younger ages (e.g., 18-24), being in a relationship may actually be a liability for heterosexual men. This prior research implies that there may be some cultural sanctions against being in a relationship at such a young age. For example, heterosexual men at younger ages are encouraged to be free, to date around, to sow wild oats, etc., activities that would be prohibited within the confines of a relationship. Perhaps heterosexual men in this study, hypothetically experiencing restrictions on their behavior as the result of being in a relationship, don't yet recognize the personal benefits to be derived from being coupled with someone else.

Comparisons With Other Studies

When compared to other studies of MGRC and psychological well-being, there are some interesting differences and similarities between other groups sampled and the two populations sampled in this study. With respect to the gay men in this study, the following is noted. Compared to those in the Simonsen (1999) study, the gay men in this study reported higher levels of all four factors of MGRC. The gay men in this study also reported higher levels of anger, anxiety, and depression, and less positive attitudes toward seeking psychological help. Clearly, the gay men in the Simonsen (1999) study were more well-adjusted psychologically than the college-age gay men in this study. The aforementioned age and education effects probably play a substantial role in the differences noted between these two samples of gay men. Also, 29% of the men in the Simonsen (1999) study were in some sort of relationship, compared to only 12% of the men in this study. The aforementioned beneficial effects on well-being that seem to be associated with involvement in a relationship are also likely to contribute to the differences in well-being seen between these two populations. When compared to the data reported by the authors of the GRCS (O'Neil, et al., 1986), the gay men in this study were higher in RE, lower in RAB, and similar in CWF and SPC to men classified as feminine, higher in RE, lower in RAB and SPC, and similar in CWF to men classified as androgynous, and similar in CWF and RE and substantially lower in RAB and SPC than men classified as masculine.

Compared to other studies of presumably heterosexual, college-age men, the heterosexual men in this study compare as follows. According to the data reported by O'Neil et al. (1986), the heterosexual men in this study were most similar on CWF to

androgynous men, most similar on RAB to both feminine and androgynous men, most similar on RE to masculine men, and most similar on SPC to feminine men. The heterosexual men in this study were lower on all four MGRC factors than those men in the Blazina and Watkins (1996), Good, et al. (1995), and Sharpe and Heppner (1991) studies, and nearly identical on all four factors of MGRC reported by Selby (1999). In regard to HSCL variables, the heterosexual men in this study were higher on anger, anxiety, and depression than those college-age men in the both the Good, et al. (1996) and Selby (1999) studies. The heterosexual men in this study had slightly more positive attitudes about seeking psychological help than those in the Blazina and Watkins (1996) study.

Limitations of the Study

There are some qualifications that must be made when considering the results of this study. As with all research that involves volunteers, there is a bias inherent in the use of cooperative subjects who volunteer for research, such that they may not be representative of the general population. Also, as with all surveys, the data are limited by the time at which they are collected. Since prior research has shown MGRC to be dynamic over the life span, it is reasonable to assume that problems with MGRC may fluctuate depending on subjects' current life circumstances, and therefore may vary depending on when those problems with MGRC are surveyed.

Since the samples used in this study were rather narrowly restricted by age, their results may not generalize to other age groups. Since the samples were narrowly restricted by locale, their results may not generalize to other geographic regions. Although both samples were more diverse than most other studies of MGRC with respect

to race/ethnicity, they were still somewhat restricted by race or ethnic group. Comparison of results from the gay men was limited to the one other study of MGRC in gay men; any other comparisons must be made to samples of presumably heterosexual men. Although the two samples in this study were more similar than different with respect to MGRC and psychological well-being, a more diverse sample of gay men might be shown to experience MGRC quite differently from this sample. Finally, there may be a selection bias in the gay men used in this study. Although this researcher and de facto research assistants strived to obtain as diverse a sample of gay men as possible, approximately 75% of gay subjects came from the Gay and Lesbian Association of Denton/COURAGE. It must be acknowledged that gay men who participate in this group, because of its visibility, may be further along in the gay identity development process and/or more comfortable with their sexual orientation and therefore may not be fully representative of gay men as a whole from the campus population.

Directions for Future Research

Future research needs uncovered by the results of this study include the following. Because of the somewhat unexpected findings for heterosexual men based on their relationship status, one interesting approach might be to study MGRC and well-being in heterosexual men with relationship status as a variable. Similarly, because well-being was shown to be strongly related to relationship status for the gay men, another approach would be to examine MGRC and well-being in a sample of gay men, also with relationship status as a variable. The study of MGRC in racial/ethnic minorities has been somewhat neglected in prior masculinity research, so this issue deserves much more attention. Utilizing age as a variable, MGRC across the life span of gay men might be an

area for further investigation. Likewise, another study of MGRC across the life span of heterosexual men would be interesting to see if the results replicated those showing how MGRC changes for heterosexual men as they age (Cournoyer & Mahalik, 1995). Finally, another study utilizing these same variables in a similar population might replicate the results found here.

This study has added much needed data to the knowledge base of how gay men specifically are affected by rigid male sex roles, and has also added to knowledge of how gay men and heterosexual men differ with respect to traditional male role expectations. Clearly, the most notable finding in this study was the fact that, with respect to both MGRC variables and psychological well-being variables, the two groups were far more similar than they were different. Mental health professionals may find such information useful when considering the negative consequences that men, regardless of sexual orientation, are likely to experience when they feel bound by traditional male gender roles.

APPENDIX A
MEASURES

Informed Consent

Dear Reader:

I would greatly appreciate your participation in my research study. The purpose of this research is to explore the relationships among different variables, including your feelings about yourself, as well as your feelings about interacting with other people. We hope that this study will be useful in helping us to better understand personal belief systems.

As part of your participation in this study, I am asking you to respond to the questionnaires in this packet; most people can complete these in about 30 minutes. General information about such things as your age, ethnicity, and beliefs will be collected, but no specific information that personally identifies you will be asked.

Please answer all questions based on your true feelings and beliefs. Please keep this consent form and return your questionnaires to the person who gave them to you. Do not write your name anywhere on the questionnaires; we want the answers you give to be completely anonymous.

The information on the questionnaires is being collected for research purposes. There is no foreseeable personal risk or discomfort involved in participating in this research as long as you keep your answers anonymous. Your participation is completely voluntary. You may withdraw from the research at any time.

Since the information received from you is anonymous, and since your participation in this research is voluntary, you agree that any information obtained from this research may be used in any way thought best by the researchers for educational research purposes. If you have any questions, concerns, or problems associated with your participation in this research study, you should contact the researcher, David Shepard, at (940) 565-2631 (e-mail dshepard@jove.acs.unt.edu), or the faculty sponsor, Dr. Ed Wakins, at (940) 565-2671.

This project has been reviewed and approved by The University of North Texas
Committee for the Protection of Human Subjects, (940) 565-3940.

Demographic Questionnaire

- | | | |
|--|---|--|
| 1. Age _____ | 2. Sex
___ 0) male
___ 1) female | 3. Race/Ethnicity
___ 1) Asian/Pacific Islander
___ 2) Black
___ 3) Hispanic
___ 4) Native American
___ 5) White
___ 6) Biracial/Multiracial |
| 4. Which of the following best describes you?
___ 1) heterosexual
___ 2) bisexual
___ 3) homosexual | 5. Education (highest level)
___ 1) some high school
___ 2) high school graduate
___ 3) some college
___ 4) Bachelor's degree
___ 5) Master's degree
___ 6) Doctoral degree | |
| 6. Religion
___ 1) Catholic
___ 2) Jewish
___ 3) Protestant
___ 4) Other _____
___ 5) none | 7. My religious beliefs are:
___ 1) very important to me
___ 2) somewhat important to me
___ 3) slightly important to me
___ 4) not at all important to me | |
| 8. What is your current relationship status?
___ 1) single
___ 2) married/in a monogamous relationship
___ 3) in a non-monogamous relationship
___ 4) divorced
___ 5) widowed | | |

Gender Role Conflict Scale

Please respond to the items below using the following scale.

- 1 = strongly disagree
- 2 = disagree
- 3 = moderately disagree
- 4 = moderately agree
- 5 = agree
- 6 = strongly agree

1. ___ Moving up the career ladder is important to me.
2. ___ I have difficulty telling others I care for them.
3. ___ Verbally expressing my love to another man is difficult for me.
4. ___ I feel torn between my hectic work schedule and caring for my health.
5. ___ Making money is a part of my idea of being a successful man.
6. ___ Strong emotions are difficult for me to understand.
7. ___ Affection with other men makes me tense.
8. ___ I sometimes define my personal value by my career success.
9. ___ Expressing feelings makes me feel open to attack by other people.
10. ___ Expressing my emotions to other men is risky.
11. ___ My career, job, or school affairs affect the quality of my leisure or family life.
12. ___ I evaluate other people's value by their level of achievement and success.
13. ___ Talking (about my feelings) during sexual relations is difficult for me.
14. ___ I worry about failing and how it affects my doing well as a man.
15. ___ I have difficulty expressing my emotional needs to my partner.
16. ___ Men who touch other men make me uncomfortable.
17. ___ Finding time to relax is difficult for me.
18. ___ Doing well all the time is important to me.
19. ___ I have difficulty expressing my tender feelings.
20. ___ Hugging other men is difficult for me.
21. ___ I often feel I need to be in charge of those around me.
22. ___ Telling others of my strong feelings is not part of my sexual behavior.
23. ___ Competing with others is the best way to succeed.
24. ___ Winning is a measure of my value and personal worth.
25. ___ I often have trouble finding words that describe how I feel.
26. ___ I am sometimes hesitant to show my affection to men because of how others might perceive me.
27. ___ My need to work or study keep me from my family or leisure more than I would like.
28. ___ I strive to be more successful than others.
29. ___ I do not like to show my emotions to others people.
30. ___ Telling my partner my feelings about her/him during sex is difficult for me.
31. ___ My work or school often disrupts other parts of my life (home, health, leisure)

Gender Role Conflict Scale (continued)

1 = strongly disagree

2 = disagree

3 = moderately disagree

4 = moderately agree

5 = agree

6 = strongly agree

- 32. ____ I am often concerned about how others evaluation my performance at work or school.
- 33. ____ Being very personal with other men makes me feel uncomfortable.
- 34. ____ Being smarter or physically stronger than other men is important to me.
- 35. ____ Men who are overly friendly to me make me wonder about their sexual preference (men or women)
- 36. ____ Overwork and stress, caused by a need to achieve on the job or in school, affects/hurts my life.
- 37. ____ I like to feel superior to other people.

Hopkins Symptom Checklist

Below you will find a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please rate how much that problem has bothered or distressed you DURING THE PAST TWO WEEKS INCLUDING TODAY. To make your rating, use the scale shown in the example. Place that number in the open space to the left of the problem or complaint. Do not skip any items, and print your answer number clearly.

Example: How much were you distressed by:

 3 Backaches

Ratings: 1 = not at all
 2 = a little bit
 3 = quite a bit
 4 = extremely

If you feel that "Backaches" have been bothering you quite a bit during the past two weeks, you would record your response "3" as shown.

DURING THE PAST TWO WEEKS, INCLUDING TODAY, HOW MUCH WERE YOU BOTHERED BY:

1. Headaches
2. Nervousness or shakiness inside
3. Being unable to get rid of bad thoughts or ideas
4. Fainting
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. Bad dreams
8. Difficulty in speaking when you are excited
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in the heart or chest
13. Itching
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Sweating
17. Trembling
18. Feeling confused
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex

Hopkins Symptom Checklist (continued)

DURING THE PAST TWO WEEKS, INCLUDING TODAY, HOW MUCH WERE YOU BOTHERED BY:

Ratings: 1 = not at all
2 = a little bit
3 = quite a bit
4 = extremely

- 22. ___ A feeling of being trapped or caught
- 23. ___ Suddenly scared for no reason
- 24. ___ Temper outbursts you could not control
- 25. ___ Constipation
- 26. ___ Blaming yourself for things
- 27. ___ Pains in the lower part of your back
- 28. ___ Feeling blocked or stymied in getting things done
- 29. ___ Feeling lonely
- 30. ___ Feeling blue
- 31. ___ Worrying or stewing about things
- 32. ___ Feeling no interest in things
- 33. ___ Feeling fearful
- 34. ___ Your feelings being easily hurt
- 35. ___ Having to ask others what you should do
- 36. ___ Feeling others do not understand you or are unsympathetic
- 37. ___ Feeling that people are unfriendly or dislike you
- 38. ___ Having to do things very slowly in order to be sure you are doing them right
- 39. ___ Heart pounding or racing
- 40. ___ Nausea or upset stomach
- 41. ___ Feeling inferior to others
- 42. ___ Soreness of your muscles
- 43. ___ Loose bowel movements
- 44. ___ Difficulty in falling asleep or staying asleep
- 45. ___ Having to check and double check what you do
- 46. ___ Difficulty making decisions
- 47. ___ Wanting to be alone
- 48. ___ Trouble getting your breath
- 49. ___ Hot or cold spells
- 50. ___ Having to avoid certain places or activities because they frighten you
- 51. ___ Your mind going blank
- 52. ___ Numbness or tingling in parts of your body
- 53. ___ A lump in your throat
- 54. ___ Feeling hopeless about the future

Hopkins Symptom Checklist (continued)

DURING THE PAST TWO WEEKS, INCLUDING TODAY, HOW MUCH WERE
YOU BOTHERED BY:

Ratings: 1 = not at all
2 = a little bit
3 = quite a bit
4 = extremely

- 55. ____ Trouble concentrating
- 56. ____ Weakness in parts of your body
- 57. ____ Feeling tense or keyed up
- 58. ____ Heavy feelings in your arms and legs

Rosenberg Self-Esteem Scale

Using the numbers given below, please indicate how much you agree or disagree with each statement. Please write your answer in the space that precedes the question.

- 1 = strongly disagree
- 2 = disagree
- 3 = agree
- 4 = strongly agree

1. ____ I feel that I'm a person of worth, at least on an equal basis with others.
2. ____ I feel that I have a number of good qualities.
3. ____ All in all, I am inclined to feel that I am a failure.
4. ____ I am able to do things as well as most other people.
5. ____ I feel I do not have much to be proud of.
6. ____ I take a positive attitude toward myself.
7. ____ On the whole, I am satisfied with myself.
8. ____ I wish I could have more respect for myself
9. ____ I certainly feel useless at times.
10. ____ At times I think I am no good at all.

Attitudes Toward Seeking Professional Psychological Help Scale

Please respond to the questions below using the following scale:

- 1 = strongly disagree
- 2 = disagree
- 3 = agree
- 4 = strongly agree

1. ___ Although there are clinics for people with mental troubles, I would not have much faith in them.
2. ___ If a good friend asked my advice about a mental problem, I might recommend that he see a psychologist.
3. ___ I would feel uneasy going to a psychologist because of what people might think.
4. ___ A person with a strong character can get over mental conflicts by himself, and would have little need of a psychologist.
5. ___ There are times when I felt completely lost and would have welcomed professional advice for a personal or emotional problem.
6. ___ Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
7. ___ I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. ___ I would rather live with certain mental conflicts than go through the ordeal of getting psychological treatment.
9. ___ Emotional difficulties, like many things, tend to work themselves out.
10. ___ There are certain problems which should be discussed outside one's immediate family.
11. ___ A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
12. ___ If I believed I was having a mental breakdown, my first inclination would be to get professional help.
13. ___ Keeping one's mind on the job is a good solution for avoiding personal worries and concerns.
14. ___ Having been a psychiatric patient is a blot on a person's life.
15. ___ I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. ___ A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.
17. ___ I resent a person—professional trained or not—who wants to know about my personal difficulties.
18. ___ I would want to get psychological attention if I was worried or upset for a long period of time.

Attitudes Toward Seeking Professional Psychological Help Scale (continued)

1 = strongly disagree

2 = disagree

3 = agree

4 = strongly agree

- 19. ____ The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
- 20. ____ Having been mentally ill carries with it a burden of shame.
- 21. ____ There are experiences in my life I would not discuss with anyone.
- 22. ____ It is probably best not to know everything about oneself.
- 23. ____ If I were experiencing a serious emotional crisis at any point in my life, I would be confident that I could find relief in psychotherapy.
- 24. ____ There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.
- 25. ____ At some future time I might want to have psychological counseling.
- 26. ____ A person should work out his problems; getting psychological counseling would be a last resort.
- 27. ____ Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."
- 28. ____ If I thought I needed psychological help, I would get it no matter who knew about it.
- 29. ____ It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.

APPENDIX B

TABLES

Table 1
Demographic Frequency Data.

	Heterosexual Men (n = 96)		Gay Men (n = 102)	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Race/Ethnicity				
Asian/Pacific Islander	4	4	0	0
Black	17	18	6	6
Hispanic	9	9	17	17
Native American	2	2	0	0
White	64	67	68	67
Biracial/Multiracial	0	0	11	11
Education				
some high school	1	1	0	0
high school graduate	15	16	5	5
some college	78	81	85	83
Bachelor's degree	2	2	12	12
Master's degree	0	0	0	0
Doctoral degree	0	0	0	0
Religion				
Catholic	16	17	5	5
Jewish	0	0	0	0
Protestant	35	37	13	13
Other	23	24	42	41
None	22	23	36	35
Importance of Religious Beliefs				
very important	46	48	40	39
somewhat important	25	26	7	7
slightly important	17	18	25	25
not at all important	7	7	30	29
Relationship Status				
single	66	69	90	88
married/monogamous relationship	14	15	5	5
non-monogamous relationship	16	17	7	7
divorced	0	0	0	0
widowed	0	0	0	0

Table 2
Mean, Standard Deviation, and Range Data for ASPH Scale, GRCS Subscales, HSCL Subscales, and RSE Scale.

Variable	Heterosexual Men			Gay Men			Poss. Range
	Mean	SD	Range	Mean	SD	Range	
ASPH	76.64	9.27	56-102	77.76	10.07	63-100	29-116
GRCS							
CWF	21.79	6.49	7-36	21.47	5.60	13-34	7-36
RAB	27.26	8.27	8-48	24.03	5.95	11-36	8-48
RE	30.55	8.38	10-52	31.52	7.21	16-42	10-60
SPC	51.42	10.95	26-77	49.11	13.14	21-66	13-78
HSCL							
ANG	12.73	4.02	7-27	13.35	4.44	8-23	7-28
ANX	10.57	3.84	7-24	10.52	3.66	7-20	7-28
DEP	18.55	5.76	11-41	18.41	5.49	11-32	11-44
RSE	33.04	5.14	19-40	32.28	4.57	19-40	10-40

Note. ASPH = Attitudes Toward Seeking Professional Psychological Help; GRCS = Gender Role Conflict Scale; CWF = Conflict Between Work and Family; RAB = Restrictive Affectionate Behavior Between Men; RE = Restrictive Emotionality; SPC = Success, Power, and Competition; HSCL = Hopkins Symptom Checklist; ANG = Anger; ANX = Anxiety; DEP = Depression; RSE = Rosenberg Self-Esteem.

Table 3

Correlations, Standardized Canonical Coefficients, and Canonical Correlations for MGRC and Well-Being Variables and Their Corresponding Canonical Variates for Heterosexual Men.

	<u>First Canonical Root</u>		<u>Second Canonical Root</u>	
	<u>Correlation</u>	<u>Coefficient</u>	<u>Correlation</u>	<u>Coefficient</u>
MGRC Variables				
CWF	.647	.529	.711	.885
RAB	.125	-.438	-.229	.058
RE	.772	.843	-.519	-.574
SPC	.445	.139	-.278	-.308
Well-Being Variables				
ASPH	-.697	-.536	.687	.871
ANG	.661	.319	.513	.138
ANX	.571	.218	.384	-.019
DEP	.718	-.009	.526	.517
RSE	-.766	-.388	-.325	-.203
Canonical Correlation	.499**		.420*	
Squared Canonical Correlation	.249		.177	

Note. MGRC = Masculine Gender Role Conflict; CWF = Conflict Between Work and Family; RAB = Restrictive Affectionate Behavior Between Men; RE = Restrictive Emotionality; SPC = Success, Power, and Competition; ASPH = Attitudes Toward Seeking Professional Psychological Help; ANG = Anger; ANX = Anxiety; DEP = Depression; RSE = Self-Esteem

* $p < .025$ ** $p < .001$

Table 4

Correlations, Standardized Canonical Coefficients, and Canonical Correlations for MGRC and Well-Being Variables and Their Corresponding Canonical Variates for Gay Men.

	<u>First Canonical Root</u>		<u>Second Canonical Root</u>	
	<u>Correlation</u>	<u>Coefficient</u>	<u>Correlation</u>	<u>Coefficient</u>
MGRC Variables				
CWF	-.102	-.108	.269	.017
RAB	-.827	-.761	.336	-.160
RE	-.232	.371	.972	1.102
SPC	-.795	-.560	.135	-.158
Well-Being Variables				
ASPH	-.384	-.599	-.229	-.058
ANG	-.459	.195	.471	-1.002
ANX	-.096	.805	.797	-.091
DEP	-.273	-.183	.852	1.797
RSE	.720	1.231	-.581	.001
Canonical Correlation	.887**		.757**	
Squared Canonical Correlation	.786		.573	

Note. MGRC = Masculine Gender Role Conflict; CWF = Conflict Between Work and Family; RAB = Restrictive Affectionate Behavior Between Men; RE = Restrictive Emotionality; SPC = Success, Power, and Competition; ASPH = Attitudes Toward Seeking Professional Psychological Help; ANG = Anger; ANX = Anxiety; DEP = Depression; RSE = Self-Esteem

**p < .001

Table 5
Correlations Among Continuous Variables for Heterosexual Men.

	Age	ASPH	ANG	ANX	DEP	CWF	RAB	RE	SPC	RSE
Age	1.00									
ASPH	-.12	1.00								
ANG	-.02	-.12	1.00							
ANX	.14	-.11	.45**	1.00						
DEP	.10	-.23*	.74**	.69**	1.00					
CWF	.09	-.02	.39**	.33**	.40**	1.00				
RAB	-.01	-.11	.04	.10	.02	.15	1.00			
RE	-.06	-.42**	.14	.16	.16	.17	.50**	1.00		
SPC	.16	-.24*	.15	.15	.13	.27**	.43**	.42**	1.00	
RSE	-.04	.26**	-.49**	-.40**	-.56**	-.31**	.08	-.21*	-.03	1.00

Note. ASPH = Attitudes Toward Seeking Professional Psychological Help;
ANG = Anger; ANX = Anxiety; DEP = Depression; CWF = Conflict Between Work and
Family; RAB = Restrictive Affectionate Behavior Between Men; RE = Restrictive
Emotionality; SPC = Success, Power, and Competition; RSE = Self-Esteem

* $p < .05$ ** $p < .01$

Table 6
Correlations Among Continuous Variables for Gay Men.

	Age	ASPH	ANG	ANX	DEP	CWF	RAB	RE	SPC	RSE
Age	1.00									
ASPH	.58**	1.00								
ANG	.17	.32	1.00							
ANX	.34**	.17	.61**	1.00						
DEP	.17	.09	.86**	.84**	1.00					
CWF	-.15	.13	.24*	.32**	.27**	1.00				
RAB	.16	.21*	.43**	.21*	.40**	.03	1.00			
RE	-.15	-.10	.44**	.60*	.68**	.25*	.52**	1.00		
SPC	-.23*	.24*	.39**	.21*	.29**	.12	.45**	.33**	1.00	
RSE	.06	.03	-.65**	-.62**	-.72**	-.22*	-.64**	-.58**	-.61**	1.00

Note. ASPH = Attitudes Toward Seeking Professional Psychological Help;
ANG = Anger; ANX = Anxiety; DEP = Depression; CWF = Conflict Between Work and
Family; RAB = Restrictive Affectionate Behavior Between Men; RE = Restrictive
Emotionality; SPC = Success, Power, and Competition; RSE = Self-Esteem

* $p < .05$ ** $p < .01$

Table 7

Means, Standard Deviations, and T-Test Values Comparing Heterosexual and Gay Men on RAB Items from GRCS.

	M	SD	t
3. Verbally expressing my love to another man is difficult for me.			2.43*
H	3.92	1.50	
G	3.41	1.46	
7. Affection with other men makes me tense.			3.53**
H	3.72	1.49	
G	2.94	1.63	
10. Expressing my emotions to other men is risky.			-4.10**
H	3.54	1.45	
G	4.35	1.33	
16. Men who touch other men make me uncomfortable.			6.83**
H	3.32	1.56	
G	1.88	1.41	
20. Hugging other men is difficult for me.			5.80**
H	2.96	1.51	
G	1.82	1.25	
26. I am sometimes hesitant to show my affection to men because of how others might perceive me.			-2.49*
H	3.29	1.39	
G	3.82	1.58	
33. Being very personal with other men makes me feel uncomfortable.			6.95**
H	3.27	1.42	
G	1.94	1.26	
35. Men who are overly friendly to me make me wonder about their sexual preference.			-2.45*
H	3.20	1.60	
G	3.82	1.89	

Note. For each t-test, $df = 196$. RAB = Restrictive Affectionate Behavior; GRCS = Gender Role Conflict Scale; H = heterosexual men; G = gay men.

* $p < .025$ ** $p < .001$

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